

**191—37.10 (514D) Standard Medicare supplement benefit plans for 2010 standardized Medicare supplement benefit plan policies or certificates with an effective date for coverage on or after June 1, 2010.** The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to Medicare supplement policies and certificates with an effective date for coverage before June 1, 2010, remain subject to the requirements of rules 191—37.6(514D) and 191—37.9(514D).

**37.10(1)** Issuer to make form available.

*a.* An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic (core) benefits, as defined in subrule 37.8(2).

*b.* If an issuer makes available any of the additional benefits described in subrule 37.8(3) or offers standardized benefit Plans K or L (as described in paragraphs 37.10(5) “*h*” and “*i*”), then the issuer shall make available to each prospective policyholder and certificate holder, in addition to a policy form or certificate form with only the basic (core) benefits as described in paragraph 37.10(1) “*a*,” a policy form or certificate form containing either standardized benefit Plan C (as described in paragraph 37.10(5) “*c*”) or standardized benefit Plan F (as described in paragraph 37.10(5) “*e*”).

**37.10(2)** No groups, packages or combinations of Medicare supplement benefits other than those listed in this rule shall be offered for sale in this state, except as may be permitted in subrule 37.10(6) and rule 191—37.11(514D).

**37.10(3)** Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans listed in rule 191—37.10(514D) and conform to the definitions in rule 191—37.3(514D). Each benefit plan shall be structured in accordance with the format provided in subrules 37.8(2) and 37.8(3), or, in the case of Plan K or L, each benefit plan shall be structured in accordance with the format provided in paragraphs 37.10(5) “*h*” and “*i*.” Each plan shall list the benefits in the order shown. For purposes of this rule, “structure, language, and format” means style, arrangement and overall content of a benefit.

**37.10(4)** In addition to the benefit plan designations required in subrule 37.10(3), an issuer may use other designations to the extent permitted by law.

**37.10(5)** Makeup of 2010 standardized benefit plans.

*a.* Standardized Medicare supplement benefit Plan A shall include only the following: The basic (core) benefits as defined in subrule 37.8(2).

*b.* Standardized Medicare supplement benefit Plan B shall include only the following: The basic (core) benefit as defined in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible as defined in paragraph 37.8(3) “*a*.”

*c.* Standardized Medicare supplement benefit Plan C shall include only the following: The basic (core) benefit as defined in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3) “*a*,” “*c*,” “*d*,” and “*f*,” respectively.

*d.* Standardized Medicare supplement benefit Plan D shall include only the following: The basic (core) benefit as defined in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3) “*a*,” “*c*,” and “*f*,” respectively.

*e.* Standardized Medicare supplement (regular) Plan F shall include only the following: The basic (core) benefit as defined in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3) “*a*,” “*c*,” “*d*,” “*e*,” and “*f*,” respectively.

*f.* Standardized Medicare supplement Plan F with high deductible shall include only the following: 100 percent of covered expenses following the payment of the annual deductible set forth in subparagraph 37.10(5) “*f*”(2).

(1) The basic (core) benefit as defined in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3) “*a*,” “*c*,” “*d*,” “*e*,” and “*f*,” respectively.

(2) The annual deductible in Plan F with high deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by (regular) Plan F, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be \$1,500 and shall be adjusted annually from 1999 by the Secretary of the U.S. Department of Health and Human Services to reflect the change in the consumer price index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars.

*g.* Standardized Medicare supplement benefit Plan G shall include only the following: The basic (core) benefit as defined in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3) “*a*,” “*c*,” “*e*,” and “*f*,” respectively.

*h.* Standardized Medicare supplement Plan K is mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

(1) Part A hospital coinsurance from the sixty-first through ninetieth day: Coverage of 100 percent of the Part A hospital coinsurance amount for each day used from the sixty-first through the ninetieth day in any Medicare benefit period;

(2) Part A hospital coinsurance from the ninety-first through one hundred fiftieth day: Coverage of 100 percent of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the ninety-first through the one hundred fiftieth day in any Medicare benefit period;

(3) Part A hospitalization after 150 days: Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer’s payment as payment in full and may not bill the insured for any balance;

(4) Medicare Part A deductible: Coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subparagraph 37.10(5) “*h*”(10);

(5) Skilled nursing facility care: Coverage for 50 percent of the coinsurance amount for each day used from the twenty-first day through the one hundredth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in subparagraph 37.10(5) “*h*”(10);

(6) Hospice care: Coverage for 50 percent of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in subparagraph 37.10(5) “*h*”(10);

(7) Blood: Coverage for 50 percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in subparagraph 37.10(5) “*h*”(10);

(8) Part B cost sharing: Except for coverage provided in subparagraph 37.10(5) “*h*”(9), coverage for 50 percent of the cost sharing otherwise applicable under Medicare Part B after the policyholder or certificate holder pays the Part B deductible until the out-of-pocket limitation is met as described in subparagraph 37.10(5) “*h*”(10);

(9) Part B preventive services: Coverage of 100 percent of the cost sharing for Medicare Part B preventive services after the policyholder or certificate holder pays the Part B deductible; and

(10) Cost sharing after out-of-pocket limits: Coverage of 100 percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of \$4000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

*i.* Standardized Medicare supplement Plan L is mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

- (1) The benefits described in subparagraphs 37.10(5) “*h*”(1), (2), (3) and (9);
- (2) The benefits described in subparagraphs 37.10(5) “*h*”(4), (5), (6), (7) and (8), but substituting 75 percent for 50 percent; and
- (3) The benefit described in subparagraph 37.10(5) “*h*”(10), but substituting \$2000 for \$4000.

*j.* Standardized Medicare supplement Plan M shall include only the following: The basic (core) benefit as defined in subrule 37.8(2), plus 50 percent of the Medicare Part A deductible, 100 percent of skilled nursing facility care, and 100 percent of medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3) “*b*,” “*c*,” and “*f*,” respectively.

*k.* Standardized Medicare supplement Plan N shall include only the following: The basic (core) benefit as defined in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3) “*a*,” “*c*,” and “*f*,” respectively, with copayments in the following amounts:

- (1) The lesser of \$20 or the Medicare Part B coinsurance or copayment for each covered health care provider office visit (including visits to medical specialists); and
- (2) The lesser of \$50 or the Medicare Part B coinsurance or copayment for each covered emergency room visit; however, this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

**37.10(6)** New or innovative benefits. An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits, in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits shall include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available, and are cost-effective. Approval of new or innovative benefits must not adversely impact the goal of Medicare supplement simplification. New or innovative benefits shall not include an outpatient prescription drug benefit. New or innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan. The commissioner shall use any guidelines issued by the National Association of Insurance Commissioners in determining whether to approve new or innovative benefits.